2012 OE Week Themes – D&R Incident video discussion

- Over 70 Chevron and Contract Partner supervisors led group discussions.
- Many groups decided to partner up so that two or more supervisors and work groups were in a single meeting.
- Over 1100 Employees and Contract Partners at Richmond have participated in this discussion.

The OE week activity was intended to highlight that incidents can and do happen in our work at our refinery – and they can have serious consequences. Additionally, the discussion was designed to provide a time for workers to build a common understanding of Why we have Operational Discipline, and do Every Task the Right Way, Every Time – Always.

In order to prepare supervisors for meaningful discussion with their work groups – a cascading message was initiated by the Refinery Manager and Leadership Team to kick off this event. Supervisors were given as much time as needed to understand the material, and prepare for their event with either customized questions, facilitators, or logistically plan their meetings.

The workforce rollout period was implemented over the course of three weeks and coincided with USW contract negotiations. Despite that potential barrier to discussion, many Operations and Maintenance work groups provided response sheets prior to and during the negotiation process. Just one testament to the common thread that was repeated by every work group,

We all care about our Chevron family.
We want to prevent incidents from happening in our refinery.

Overall themes will be shared back during 2012 Business Plan Roll Out – and subsequent IIFLT activities and website documents. The themes presented below are a culmination of the conversations that took place in the refinery and were generated and reviewed by the IIFLT. The IIFLT asserts that Operational Disciple, IIF, HES and PSM efforts currently addresses the ways and means to forward our performance in these areas.

Every Task the Right Way, Every Time – Always

- **We all care about our Chevron family**. The incident (and video) deeply impacted all of us. We share a bond and have care and concern for everyone who works in the refinery. **Incidents here impact our work family, people we care about (friends, husbands, sons, daughters), and incidents can have horrible consequences. We want to prevent incidents from happening at Richmond Refinery.**
- At least temporarily, this discussion and video clearly reinforced why we must complete every task right way every time. This incident discussion caused us to reflect on current projects to ensure we are doing every task the right way, every time. **In order to**

prevent the worst from happening, we can't forget the importance of doing things right, providing appropriate leadership, and commitment to Operational Excellence.

- All tasks should be thought of as critical - to be performed correctly every time. We need to ensure people are trained and using the tools we have.
- As Leaders, we need to take personal responsibility to make sure everyone feels comfortable using the Tenets, procedures, SWPs with excellence. We need to coach the right behaviors, and be sensitive of when we are pushing the work. By focusing on the right behaviors (appropriate for the task), we'll prevent situations where people feel rushed and we will avoid performing the poor quality work.
- There are many non standard situations, things change quickly. Following Operational Procedures and Safe Work Practices up front is critical, but we need to have adaptability.
- Consistency and accuracy are critical in our communications. Operations and Company Rep Turnovers can be improved upon to ensure consistency in communications – particularly when it comes to critical jobs and when moving from day to night shift.

Maintaining a sense of vulnerability

- There were many comments related to maintaining a sense of vulnerability, particularly after incidents occur. Our sense of vulnerability goes hand in hand with excellence in Hazard Identification and Risk Recognition for all of our tasks. We need to continue to engrain risk recognition for all of our tasks by asking ourselves, "Where am I are being complacent"?
- We agreed that in terms of preventing incidents – our sense of vulnerability should be associated with the small things, seemingly minor details – which can cause the greatest harm.
- Anyone of us can be involved in an incident or injury, making assumptions about tasks inhibits a sense of vulnerability, understanding who is making decisions and why builds clarification of hazards, risks, and maintaining a sense of vulnerability.
- As Leaders, maintaining a sense of vulnerability means we will: recognize changes and shift expectations when needed, involve the right people, give feedback to work groups during observations (LPOs – specifically on Safe Work Practices and Procedures), and spend time in the plant where we can verify that tasks are being completed correctly.

Using our Tools with excellence – Where we need to continue to improve

- Hazard Identification and Risk Recognition practices. Most noted: Complete LPSAs and Stop/ Pause Work Authority when warranted. As Leaders, we can promote Stop/ Pause Work Authority by having conversation about SWA before every shift, recognize and share back positives of SWA, reinforce that people have the authority to use and receive SWA, and support our peers in using SWA.
- Consistent implementation of Safety Work Practices – LOTO and JJSV are critical tasks which need to be correct 100% of the time. Also, identifying, "valve normal" status (open or close), and identify which Procedures apply to each job.
- Consistent use of correct Operational Procedures. We need resources to keep documents "ever green" and build on the documents we currently have. For procedures, have more eyes looking at it the better. One suggestion is to use the whole crew to review Procedures, instead of just

one or two people. Other support groups are developing desk guides and manuals to document processes

- We also need to confirm that what we just did (actions taken) were what was intended and is correct.

Summary of All Responses

Question 1: Overall

How did the D&R incident /video impact you?

1. Clearly reinforced every task right way every time, importance of doing things safe, exhibit leadership, OE commitment, reflect on project currently working on to ensure proper sign offs.
2. It can happen to me, you, anyone. Routine tasks create a false sense of security, new employees had not see event of this type before, incidents can happen here... to people you know.
3. Frustration. Difficult to watch based on past incidents. Same incident occurred elsewhere.
4. Incidents here impact our work family, coworkers we care about, they can have horrible consequences. The incident deeply impacted all of us, we share a bond and have care and concern for everyone who works in the refinery. This is our refinery – the incident and video hits close to home.
5. Fatigue, stress of those involved in incident, start up and shut down time periods are more dangerous.

Question 2: OD Tools

What would it have taken for the outcome of this incident to have been even more serious, or prevented entirely?

1. Use of SWA, SWP, Haz. ID practices, more effective use of LPSA, using SWA to halt field T/O.
2. Not one clear picture of who is doing what, who was in charge, risk recognition for the group was missing,
3. Hardest part of our work is moving from a S/D plant to a running plant – in regards to following SWPs.
4. Complacency sets in when tasks is repetitive, lowers people sense of vulnerability, we need a constant sense of awareness.
5. Do complete turnovers even when things are going well or when conditions change

Question 3: OD Hazards and Risks

What are our critical tasks that always need to be done right every time? Are we identifying the hazards and potential consequences fully? If not, what needs to be done?

1. All tasks should be thought of as critical to be performed correct every time, ensure people are trained using the tools, coaching by asking and not by telling, be sensitive of pushing the work

by driving the right behavior and not rushing as to avoid performing the work with poor quality, clear precise tasks and ensure procedures
2. LPSA and SWA (when needed), perform LPSA at beginning of every task
3. Using procedures, performing routine duties, responding to deviations
4. LOTO, JJSV critical task needs to be correct 100% of the time, ID valve normal status (open or close), ID what procedures apply.
5. Confirming that what we just did (actions taken) are what was intended and is correct. Ensuring documentation is correct Performing PM or inspection repairing equipment following EWOs,
6. Involving the right people, give feedback to work groups during observations, HO spends more time on admin duties and less time in plant with workers
7. Share lessons learned, near losses, and hazards, proactively share.

Question 4: Sense of Vulnerability

Can a similar incident happen to you or your coworkers? What situations trigger a greater level of attention in you? What do you do differently when those situations occur?

1. It can happen to anyone of us.
2. Attention to detail on the routine tasks, the smallest details can have the largest of impacts.
3. Engrain risk recognition, all it would have taken was 15 seconds to prevent this from happening
4. It seems many incidents are associated with LOTO is there anything that we can do to improve this area?"
5. The key is to understand the risk where we are at and address it
6. High risk jobs, non routine work, unfamiliar work are the areas we pay the most attention

Question 5: Stop / Pause Work Authority

Describe how and when Stop/ Pause Work Authority could have been used to prevent this incident. What do we need to do to ensure successful Stop/ Pause Work Authority?

1. Use SWA to complete an LPSA anytime we are unsure of the situation.
2. Recognize and share back positives of SWA.
3. Reinforce that people have the authority to use and receive SWA.
4. Support our peers in using SWA.
5. Leadership - Have a conversation about SWA before every shift. Make sure your crew is fit for duty, have a conversation that is not work related to see what is happening at home. Be aware if the schedule is driving you or are you missing a step. Supervisors can do SWA/PWA themselves to show that they are using it and make us feel more comfortable.

Question 6: Shift to Always

How did the D&R incident (or another incident) change your approach to work and keeping yourself, your family, and your Chevron family safe?

1. Leadership - I have to take personal responsibility to make sure everyone feels comfortable using the tenants.
2. We can't assume anything
3. For less experienced, exempt employees who haven't been directly affected by an incident like this, confirms the "Big Risk" that does exist for everyone.

4. Reminds us that often the small things cause the greatest harm
5. Risk of an incident goes up whenever we are comfortable with our task

Question 7: Operational Discipline

In our work, does the potential for an incident exist because expectations are situational or non-standardized? What are they? Discuss any similar scenarios.

1. Yes. There are non standard situations, things change quickly, following procedures up front can assist even in situations you are not trained for, we need to have adaptability
2. Many jobs in maintenance are non standard that is why we need to adhere to SWP
3. Leadership - As leaders it is our roles to recognize changes and shift expectations when needed.

Question 8: Communication

In our work, are there gaps in communication about equipment status, regulations, requirements, or roles and responsibilities that creates the potential for an incident? What are they?

1. Consistency and accuracy are critical in our communications.
2. SUPERVISION AND OVERSIGHT - has historically been one to the top 3 or 4 on the Major Incident Study findings.
3. Company Rep Turnovers include, Written Turnovers but not always include field walks. Incident free for Maintenance should include both on critical jobs.
4. Turnovers from days to nights can be improved to reflect changing conditions –
5. For more than 5 years we have been using an out of date electronic Turnover process Lotus Notes. We were never transferred to File maker Pro. Training communications are not always consistent

Question 9: OD Job Aides and Procedures

Do you have job aids, procedures, or work processes that need revising? Or, do you have job aids that should be procedures because of the risk associated with them? Discuss the course of action to bridge any gaps.

1. Yes –we need resources to keep documents "ever green" and building on the documents we currently have. For procedures have more eyes looking at it the better, use the whole crew, instead of just one or two people.
2. We have lots of processes to keep us safe we need to use them.
3. Leadership – We need to remove obstacles so we can get out in the field and steward our job aids.
4. LPO is another tool that helps us find flaws or corrections to our procedures.
5. Many positions are developing desk guides and manuals to document processes developed for their teams.